Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Innova Hospital

Respondent Name
Bradford Holding Company Inc

MFDR Tracking Number
M4-13-1902-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
March 27, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Based on the operative note, our coding department recommended billing with the CPT code of 29877, which best reflected the procedure that was done. Because of billing with that code, we were denied payment for not having authorization for it."

Amount in Dispute: $4,149.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor obtained preauthorization for the CPT codes 29811 and 29882, a left knee arthroscopy and medical meniscus repair, respectively. However, these are not the procedures that the Requestor performed and billed. Instead, they billed CPT code 29877 which was a arthroscopy of the knee with shaving of articular cartilage. This procedure was not preauthorized as required by DWC Rule 134.600. Therefore, Respondent properly denied the service based on lack of preauthorization."

Response Submitted by: Downs ♦ Stanford, P.C., 2001 Bryan Street, Suite 4000, Dallas, Texas 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 20, 2012	Outpatient Hospital Services	$4,149.24	$4,149.24

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 197 – Payment denied/reduced for absence of precertification/preauthorization.

Issues

1. Did the carrier support prior authorization guidelines not met?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, 197 – "Payment denied/reduced for absence of precertification/preauthorization. Review of the submitted documentation finds that Utilization Review letter dated 9/13/2012 authorized 29881 – "Arthroscopy, knee, surgical with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed". The requestor billing code 29877 – "Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty). The code 29877 is by definition part of the authorized services. Therefore, the carrier's decision is not supported. The disputed services will be reviewed per applicable rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
    - Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
    - Procedure code 29877 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $2,076.45. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,245.87. This amount multiplied by the annual wage index for this facility of 0.8978 yields an adjusted labor-related amount of $1,118.54. The non-labor related portion is 40% of the APC rate or $830.58. The sum of the labor and non-labor related amounts is $1,949.12. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,025, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. The OPPS Facility-Specific Impacts file does not list a cost-to-charge ratio (CCR) for this provider. The requestor did not submit documentation of the facility CCR for consideration in this review. Per Medicare policy, when the provider's CCR cannot be determined, the CCR is estimated using the statewide average CCR as found in Medicare's OPPS Annual Policy Files. Medicare lists the Urban Texas 2012 Default CCR as 0.1961. This ratio multiplied by the billed charge of $21,980.00 yields a cost of $4,310.28. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $1,949.12 divided by the sum of all APC payments is 100.00%. The sum of all packaged costs is $3,496.13. The allocated portion of packaged costs is $3,496.13. This amount added to the service cost yields a total cost of $7,806.41. The cost of these services exceeds the annual fixed-dollar threshold of $2,025. The amount by which the cost exceeds 1.75 times the OPPS payment is $4,395.45. 50% of this amount is $2,197.73. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $4,146.85. This amount multiplied by 200% yields a MAR of $8,293.69.

- Procedure code J2765 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

4. The total allowable reimbursement for the services in dispute is $8,293.69. The amount previously paid by the insurance carrier is $0.00. The requestor is seeking additional reimbursement in the amount of $4,149.24. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $4,149.24.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4,149.24 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 14, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.